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## **Brexit: let democratic countries choose the health service they want**

Niall McCrae

For much of the global readership of this journal, arguments on Brexit (Britain's departure from the European Union) may seem parochial: a storm in a teacup. Why should nurses in China, Brazil or the USA be concerned that the British people exercised their democratic rights in a plebiscite on membership of a transnational organisation? The UK is leaving the European Union (EU), not Europe. With London the financial capital of the world, a boom in manufacturing and tourism, highest-ever employment figures, and UK universities riding high in the world rankings, Britain can hardly be perceived as a nation in crisis. Yet anyone visiting in the last two years will be aware of the rancorous controversy. After a tense campaign, the margin of 52% to 48% in the referendum was not overwhelming, and the debate rages on.

The prevailing view of mainstream political parties, universities, corporate business leaders, bankers, and prominent figures in the media and arts was to stay in the EU. Economists warned of dire consequences in the immediate event of a vote to leave the EU, although they might have shown more humility after their abject failure to foresee the global economic crisis in 2008 (Hodgson, 2009). So-called 'Project Fear' (a Remain campaign emphasising dire consequences of leaving the EU rather than the benefits of membership) backfired, and the common people defied the establishment. A recent opinion poll (YouGov, 2017) showed that half of Remain voters now want Brexit to proceed, but a hard core of 21% continues to urge delay, dilution or reversal. Residual Remainers may seem like those out-of-touch Japanese soldiers in the depths of Malayan jungle unaware that the Second World War had ended, but they continue to have disproportionate influence. Since the referendum, the public

broadcaster BBC's popular political debate series *Question Time* has fielded 137 panellists who supported Remain, compared to 72 who supported Leave. Academic experts catastrophise the impact of Brexit on wealth and welfare, and almost daily I hear someone in a meeting of no relevance to the EU venting their 'doom and gloom' sentiments.

Frequently we are told that Brexit will have adverse consequences for healthcare: staff shortages, withdrawal from research programmes, and service cuts due to economic slump. Here, I shall present a corrective to this relentless negativity, discussing the ramifications of Brexit for the British National Health Service, for nurses, and for the people who use the UK's health services (and pay for these through taxation). This necessarily involves the thorny topic of immigration.

The fate of workers from EU countries is an understandable concern. Anxieties about continued residency rights are being exploited by Remainers in the interim uncertainty of the departure negotiations, but post-Brexit restrictions are unlikely to apply until a declared date when free movement will end. Future entry requirements should be made as flexible as possible, while satisfying the British electorate of a firm but fair immigration system. For intelligent discussion, we must move beyond the simplistic dichotomy of an on / off switch.

Many people from other EU countries work in the NHS, and in care services in the private sector such as residential homes for the elderly. However, the EU is not the main source of foreign labour, either for Britain or other European nations. Germany's biggest human import has been from Turkey, while Britain, like France, tapped into its imperial legacy to fill wide gaps in the workforce. Since the SS *Windrush* arrived at Tilbury Dock in 1948, millions have been welcomed from the West Indies, Africa, Mauritius, Hong Kong and the Indian

subcontinent. More recently, increasing numbers have arrived from Afghanistan, the Middle East, the *Mahgreb*, the Horn of Africa and Albania. EU incomers are a large but not the largest slice of the cake.

Generally, immigrants are here by mutual consent. An open, liberal society has economic and cultural advantages, as newcomers bring fresh perspectives and talents, and they do jobs that local people eschew. Recruitment problems in public services are common in relatively rich nations; this phenomenon predates the EU and transcends continents. But excessive reliance on cheap labour from abroad is no long-term answer. Instead, countries like Britain should provide better training and career opportunities for their own younger people. Meanwhile, robots are increasingly taking jobs from human beings, so that instead of a labour shortage, we may soon have oversupply.

The care-workforce in Britain is highly multicultural, and was so long before this became true of the broader populace. My history of mental hospital nursing, co-written with Peter Nolan, devotes a chapter to the experiences of nurses from overseas (McCrae & Nolan, 2016). In response to severe staff shortage, the mental hospitals became ‘ports on the hill’, and by the 1970s typically half of the staff of these institutions came from distant shores. Many of the second and third generations of the post-war influx followed the footsteps of their parents into healthcare. People of African or Asian ethnicity form the backbone of care services in the less attractive areas of mental health, learning difficulties and old age, but this work tends to be poorly rewarded. EU migration has exacerbated this, because care home owners have no need to increase pay when a multitude from eastern Europe will gladly work for the minimum wage.

Few would deny that immigration brings benefits to society, but we must be allowed to talk about the disadvantages too. A recent study of 31 NHS trusts by Germack and colleagues (2015) found an inverse correlation between the percentage of foreign nurses and patient satisfaction, after controlling for confounding factors. Cultural differences inevitably affect the quality of nurse-patient relationships, as was found in the mental hospitals in the past. A ward can maintain a high standard of communication if one or two of the staff are not native English-speakers, but this is less feasible when they are the majority. My students sometimes complain of members of nursing staff openly conversing in other languages while on duty, which seems disrespectful to patients and colleagues. To be fair, the linguistic skills of European nurses often put local people to shame, but we should not overlook the findings of Germack and colleagues. Mistakes can happen due to misunderstanding of a verbal instruction or patient's utterance.

I am not glossing over the persistent recruitment difficulties in parts of the NHS and private care sector, but employers should make more effort to recruit and retain British nurses (of all ethnicities). Another consideration is that recruitment from abroad robs poorer countries of nursing talent. In his book *After Europe*, pro-EU scholar Ivan Krastev (2017: 52) described the impact on former Communist countries such as his own homeland of Bulgaria: -

Businesses in the region constantly complain about the shortage of qualified labour. Eastern European health systems are deprived of well-trained nurses who prefer to earn several times more by taking care of a single family in London than by practising their profession in a low-paying local hospital.

The NHS is a magnet for workers but also users of health services. Apart from emergency

treatment, visitors are expected to pay for surgery or other services that would normally be provided free to UK citizens. Some medical commentators have expressed distaste for charging patients from abroad (Steele *et al*, 2017), but there are rightful concerns about so-called ‘health tourism’, where people travel to the UK to avail themselves of NHS care and avoid charges they would pay in their own country. EU law dictates that residents from other countries are treated the same as host citizens. However, the NHS was founded on a contributory principle, with each person paying through tax (National Insurance) according to their means. Eligibility should be determined by the democratically-elected British government, not by unelected EU bureaucrats. Effectively, NHS commissioning bodies and service providers are serving an unknown catchment area. Politicians and professors should heed Milton Friedman’s dictum that you can have a welfare state, or you can have open borders, but you cannot have both (Friedman & Friedman, 1990).

Leave voters are repeatedly accused of xenophobia, but this is a slur on 17.4 million people (the largest tally for a voting option in British political history). According to the EU’s own surveys, Britons’ attitudes towards immigrants from Europe have become more positive in recent years (European Commission, 2016). A tide of hate described by some influential figures in the media, such as *Guardian* columnist Polly Toynbee (13 June 2016), is not supported by evidence. By conflating scepticism towards the EU with hostility to foreigners, Remainers have posited ‘a dubious moral, rather than political, division between people who voted Brexit and those who voted Remain, the former mischaracterised as irrational and hateful (Butcher, 2017).

In my kitchen conversations with colleagues prior to the referendum, half were voting Leave. These nursing or midwifery lecturers are certainly not racist. But unlike the Utopian idealism

of students towards the EU, they struggle with the realities of getting their children into a local school or getting a doctor's appointment; their daily commute from the suburbs has become a jostle on an overcrowded train. Their concern relates to the sheer weight of numbers. The privileged class can afford to be liberal, because they do not rely so much on oversubscribed public services, having the means for private schooling, for example.

In their anti-Brexit tirades, Remainers often seem contemptuous of fellow citizens. In a punitive tone they tell Leavers that they must now pick their own potatoes, and wipe the bottoms of their own frail elders. The implication is that only immigrants are fit to do this work, but there is also a hint of inverse racism here. A lesson that should be learned in Britain (as in the USA) is that conferring undesirable traits on large swaths of the electorate is counterproductive. Silencing of legitimate concerns about uncontrolled immigration, despite its dramatic demographic impact on communities, has generated anti-establishment feelings that influenced the referendum. But this was not the main reason for the Leave vote.

As shown by opinion polling (Lord Ashcroft Polls, 9 June 2016), the main motive for Brexit was sovereignty. The majority of the British public, whatever their political party preferences, sees an optimistic future for an independent nation with its destiny in its own hands. The UK wants to be a partner, not adversary, of other European nations. EU bureaucrats should not obstruct British scientists from collaborating on clinical research, or on transnational agreements on drug regulation and ethical standards, any more than countries like Japan, Israel, Canada or New Zealand are bound by their neighbours. I appeal to Remainers to relinquish their pessimism. Britain has a proud record in the development of medicine, nursing and health services, with a rich legacy of medical discoveries, Nobel Prize winners, the founding of the nursing profession by Florence Nightingale, and creation of the NHS. If

the answer to everything is the EU, you are asking the wrong question.

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